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THU0558 ANTI-CCP NEGATIVE PATIENTS WITH NEW MUSCULOSKELETAL SYMPTOMS: IMPROVING REFERRALS FROM PRIMARY CARE

L. Garcia-Montoya^{1,2}, J. Nam^{1,2}, K. Mankia^{1,2}, L. Duquenne^{1,2}, A. Di Matteo^{1,2}, P. Emery¹. ¹LIRMM, Leeds, United Kingdom; ²Leeds Biomedical Research Centre, NIHR, Leeds, United Kingdom

Background: The presence of anti-cyclic citrullinated peptide antibodies (anti-CCP antibodies) is associated with progression to inflammatory arthritis (IA) [1]; however, most patients attending primary care with a new non-specific musculoskeletal (MSK) complaint and no clinical synovitis have a negative result for this test (CCP-). Considering that only a small proportion of these individuals will be diagnosed with an IA within the next 12 months, predicting disease progression in these patients appears to be more challenging.

Objectives: To investigate factors that could be associated with disease progression in patients testing CCP- in order to optimise primary care referrals to Rheumatology.

Methods: A prospective observational study recruiting patients over 16 years old with a new MSK complaint and no clinical synovitis was conducted. Patients recruited from primary care centres across the UK from July 2007 until November 2018 were included in this analysis. Those testing negative for the anti-CCP2 assay (initially phadia, later bioplex) were sent questionnaires 1 year later, and GPs were contacted in November 2019 to confirm their disease status.

Results: 7521 eligible patients were recruited from primary care. 7290 (97%) of them were CCP- and 5678 returned the questionnaire after 1 year. 239 patients (4.2%) of these CCP- reported progression to IA; however, this diagnosis was only confirmed in 53 of them (0.93%). In another 38 patients, the IA diagnosis could not be confirmed and therefore they were not included in the analysis. 21 patients progressed to rheumatoid arthritis (RA), 13 to spondyloarthritis, 11 to polymyalgia rheumatica (requiring disease-modifying anti-rheumatic drugs), 3 to polymyositis, 3 to systemic lupus erythematosus and 2 to systemic sclerosis. Table 1 describes the most troublesome joints and table 2 other concomitant MSK diagnoses of the non-progressors/ progressors; and among the last ones, the RA group. Multivariable analysis showed that pain in specific joints was associated with development of IA within the following 12 months: hand odds ratio (OR) 2.1 [95%CI (1.09-4.16), p=0.027], knee OR 2.0 [95%CI (1.13-3.91), p=0.02], and shoulder OR 1.8 [95%CI (1.02-3.45), p=0.043]. Smoking exposure, having a first degree relative with RA and gender were not predictive for progression. Older age showed only a slightly higher risk for IA [OR 1.04, 95%CI (1.01-1.06) p=0.001].

Table 1. Characteristics, troublesome joints of the participants

	NON-PROGRESSORS (n=5588)	PROGRESSORS (n=52)	RA progressors (n=21)
Female %	72	58	57
Mean age y.o.	53 (16-91)	60 (30-82)	60 (30-82)
FDR with RA %	38	33	33
Ever Smoked %	38	43	40
Neck pain %	30	29	14
Shoulder pain %	41	58	52
Elbow pain %	29	38	29
Wrist pain %	38	46	48
Hand pain %	53	71	76
Thumb pain %	36	48	57
Back pain %	33	25	24
Hip pain %	36	29	19
Knee pain %	55	71	62
Ankle pain %	30	23	24
Foot pain %	34	40	33

Table 2. Concomitant MSK diagnosis

	NON-PROGRESSORS (n=5588)	PROGRESSORS (n=52)	RA progressors (n=21)
Carpal tunnel syndrome %	13	17	30
Rotator cuff %	12	19	20
Trigger finger %	5	4	0
Tennis elbow %	15	10	5
Osteoarthritis %	18	25	20

Conclusion: In CCP- patients without clinical synovitis, hand, knee and shoulder pain should be investigated more carefully as these involve a higher risk of progression to IA. Patient reported outcomes regarding rheumatic diseases are not reliable; the distribution of joint pain seems to be a more useful tool than the family history when assessing the need for referral to Rheumatology.

References:

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Figure 1. Study participants and outcome

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THU0559 IMPLEMENTATION OF A TRIAGE SYSTEM IN A HOSPITAL WITH HIGH DEMAND FOR CARE

S. Ibáñez^{1,2}, F. Valenzuela¹, O. Martínez¹, O. Valenzuela^{1,2}, F. Silva^{1,2}, M. J. Villar^{1,2}, M. P. Poblete¹, C. Mardones¹. ¹Hospital Padre Hurtado, San Ramón, Chile; ²Clinica Alemana, Vitacura, Chile

Background: Our hospital has 4 Rheumatologists and is in charge of 425.000 inhabitants (1 rheumatologist per 106.250 inhabitants). In November 2017, there were 503 referrals from primary care waiting for a first visit with the rheumatologist. Given the impossibility of covering this number of waiting patients through normal operation, it was decided to implement a rapid access polyclinic that started in December of 2017.

Objectives: To evaluate the effectiveness of a triage system in a center with high demand for care.

Methods: Patients referred by the general practitioner were evaluated by a senior rheumatologist in a 10-minute consultation using a predefined interrogation, expanded case-by-case based on the criteria of each rheumatologist. According to the results of the interview, the situation of the patient was categorized into: urgent, normal rheumatology control or control in primary care. For urgent consultations, an early control polyclinic was created to evaluate these patients within the following 15 days. The usual consultations entered into the usual scheduling system. The pathologies that were considered to require control in primary care were assigned to a coordination polyclinic where the patients were evaluated by an internist, in charge of confirming the diagnosis, educating the patient, and, if applicable, refer to primary care. No patient was discharged immediately after the triage. We report the data of the first 136 patients.

Results: The waiting time was reduced from a median of 275 days (IQR 66-591) to 46.5 (23-140). Refer to table 1 for full results. In 52.2% of referred patients the suspicion of a chronic autoimmune or inflammatory disease was described in the referral note. In these patients, when comparing with patients whose referral notes did not refer to an inflammatory or autoimmune disease, the waiting time for triage was significantly shorter, the percentage of patients who were discharged from rheumatology was significantly lower, and the percentage of patients in whom a chronic autoimmune or inflammatory disease was confirmed in the first control was significantly higher.